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Executive Office of Health and Human Services  
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TO: Early Intervention Program Directors  
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FROM: Ron Benham, Director, Division of Perinatal, Early Childhood & Special Health Needs  
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DATE: December 7, 2007

RE: Administrative Update – Addressing EI System Growth

As we discussed at the November ICC meeting, DPH EI expenses are increasing due to multiple factors. This is a result of a higher number of children referred for services, an increase in services rendered by Developmental Specialists, and shifts in insurance coverage. Caseload growth appears to be the result of universal acceptance and awareness of EI and Specialty Services while the increase in Developmental Specialists has occurred because of the ongoing workforce limitations. Changes in private insurance products and coverage have resulted in increases in co-payments and deductibles as well as growth in self insured employer groups with plans that do not cover EI. At the same time, there has been expansion in the number of clients insured by Medicaid (MassHealth) which is an outcome of health care reform initiatives. There is presently no evidence to suggest that these trends will change.

Over the last several months DPH staff have been meeting with personnel from DMR, MassHealth, the Executive Office of Health and Human Services and representatives from the EI provider community to discuss possible solutions to manage increasing costs while maintaining broad eligibility and the clinical integrity of the system in light of significant workforce issues. After a thorough review of data examining the reasons for referral to EI services, eligibility, payer sources, and costs, several proposals were recommended to address the fiscal deficiencies. Based on these discussions and recommendations the following policies and practices will take effect on January 1, 2008:

- Clarification of Torticollis Diagnosis on the Established Conditions list - The EIIS Client Registration System Diagnoses List currently states ***Torticollis, congenital*** as a diagnosis that makes a child eligible for EI services. An analysis of the EI data matched to birth data shows that “only 2 of the 400 children born between July 2000 and June 2002 who received an evaluation in EI and, according to the EIIS data had congenital torticollis, actually had a diagnosis of torticollis at the hospital discharge following birth”. In FY07 the EIIS data shows 946 children eligible for EI due to congenital torticollis. The following provides clarification regarding the differences between congenital and acquired torticollis:
  - ***Congenital muscular torticollis*** occurs when the sternocleidomastoid muscle on one side of the infant's neck becomes tighter than the other, pulling the head and neck to that side. This can occur when scar tissue forms in this muscle so that it cannot grow properly. Congenital torticollis is sometimes the consequence of injury to the muscle during delivery, although it is also thought that it may occur prior to delivery and be a contributing cause to a difficult birth and not its consequence. It can also be caused by congenital abnormalities of the cervical spine, so sometimes xrays are required in evaluating newborns with torticollis. A surgical release/lengthening of the sternocleidomastoid muscle may be required.
  - Children with ***acquired torticollis*** will usually hold their neck to one side. It can be secondary to trauma or inflammation after an upper respiratory tract infection, or because the child has been lying on his/her back without much belly time to strengthen the head and neck muscles. ***Acquired torticollis*** generally improves with stretching and positioning exercises.

Infants and toddlers with ***congenital torticollis*** will be eligible for EI services. Effective January 1, 2008 a confirmed diagnosis from a physician will be required to be kept in the child's file. Children with ***acquired torticollis*** (does not require a confirmed diagnosis from a physician) will be eligible for EI if they meet the other appropriate eligibility guidelines.

- Clarify duration of eligibility– A multidisciplinary evaluation by qualified personnel must be performed to determine the child's initial and ongoing eligibility for early intervention. Early Intervention Programs are strongly encouraged to engage in discussions with families regarding ongoing EI participation for their children who are making significant progress and attaining IFSP outcomes. Effective January 1, 2008 all children eligible based on developmental delay, clinical judgment, or the at-risk criteria ***will have their eligibility for early intervention services re-determined every six months***. All six-month eligibility evaluations must be entered into the EIIS Client Registration System.

The DPH has obtained federal guidance that eligibility for EI can be determined at any time the child is attaining developmental milestones, making substantial progress, reaching IFSP outcomes with parental consent. The program will obtain consent to complete an evaluation to determine eligibility. If there is a question about the child's ongoing eligibility and the parent refuses consent to a multidisciplinary evaluation, the program may pursue resolution to the issue through mediation or an impartial due process hearing.

Children with a diagnosed established condition such as Down Syndrome or Cerebral Palsy do not need to be re-evaluated every six months to determine eligibility. Members of the IFSP team, with input from the parents, should determine if and when additional assessment is needed for those children eligible based on established conditions.

At this time the DPH will not be adding additional assessment hours to the current billing guidelines for the six-month eligibility evaluation since the statewide average number of assessment hours for IFSP children is six (6) hours per year. Therefore, programs should have ample assessment hours to complete six-month eligibility evaluations. Providers may request a waiver for additional service hours in excess of ten (10) Assessment hours annually for extraordinary circumstances. IFSPs should be written for a six month duration and the fee should be adjusted appropriately. Accordingly, the Department will update the EI Operational Standards, Notice and Consent for Eligibility Evaluation/Assessment, and the Fee Brochure to reflect this clarification.

- Discontinue use of billing IFSP development and meetings as Assessment Hours – All IFSP meetings must be billed as home visits or center based individual service. Multiple staff will continue to be able to participate in an IFSP meeting and bill it as a home visit. This is not considered a co-treatment and should be documented in the progress note. An IFSP meeting with multiple staff in excess of two hours may get rejected by Mass Health. In that case, providers may bill the DPH utilizing the appropriate reason code (payment denied/more than one visit per day). Two staff of the same discipline participating in an IFSP meeting would require a waiver.
- Discontinue billing for Intake – The activity of intake, the initial face-to-face contact with the family by the EI program to provide an opportunity for discussion with family members regarding potential participation in EI, will be billed at the assessment rate. The EIIS evaluation date must match the date of the first face-to-face contact with the family which includes the initiation of the evaluation tool. As noted above, the DPH is not increasing the number of allowable Assessment hours at this time. Providers may request a waiver for additional service hours in excess of ten (10) Assessment hours annually for extraordinary circumstances. ***Please note that intake services (CHA screening/EI Intake service) will remain in place for EIPP referred children.***
- Require ASD eligibility screening tool – A written diagnosis confirming that a child meets the DSM-IV criteria for one of the five disorders under the Autism Spectrum Disorder diagnosis must be provided by a professional familiar with the spectrum (physician, clinical psychologist, LMHC approved by DPH for this purpose). When the diagnostic appointment cannot be scheduled in a timely way, written documentation that a child is on the autism spectrum from a pediatrician or other physician will be accepted based on presumptive eligibility if it is accompanied by confirming results on an autism screening tool (such as the Modified Checklist for Autism in Toddlers [M-CHAT] or the Pervasive Developmental Disabilities Screening Test II). A written confirming diagnosis must be obtained within 180 days to continue Specialty Services Program participation.

In addition to the immediate actions effective January 1, 2008, the Department will conduct Data Verification activities via record review by regional DPH staff to verify all eligibility categories. The DPH will also be working with providers and clinicians to undertake a review of the current Established Conditions Diagnoses List and the At-Risk eligibility criteria. Finally, the DPH will continue to work closely and collaboratively with all interested parties to ensure that payment responsibility is equitably borne.

In closing, I would like to express my appreciation for the thoughtful guidance and assistance the Department has received from the EI community. The DPH has considered the implication of each policy change on families, providers, and payers and firmly believes that despite these changes the quality and integrity of EI services will remain high. The Department is committed to continuing to work with all members of the EI community to best meet the needs of families and children to the greatest extent possible and strongly encourages providers to continue to offer suggestions or ideas where efficiencies could be identified. Should you have any questions or concerns, feel free to contact Patti Fougere at (617) 624-5975 or (781) 774-6742, Rob Seymour at (617) 624-5436 or myself at (617) 624-5901.